Certificate Number:

Premium Payment Mode ☒M ☐Q ☐A

☒ Health Choice Benefit Plan (25875)
Ded ☐$1000 ☒$2000 ☐$3000 ☐ ____
R&B ☐$200 ☒$300 ☐$400 ☐$500 ☐$600 ☐ ____
☐ Signature Benefit Plan (25876)
Ded: ☐$1500 Coins: ☐50% ☐80%
Ded: ☐$2,500 ☐$5,000 ☐$7,500 ☐$10,000
Coins. ☐50% ☐80% ☐100%
☐ Critical Care (GSD) Amt. $____
☐ Premiere PPO (25877)
Ded. ☐$1,000 ☐$1,500 ☐$2,500 ☐$5,000 ☐$7,500
☐ Premiere PPO Plus (25877)
Ded. ☐$1,000 ☐$1,500 ☐$2,500 ☐$5,000
☐ HIPAA ☐ Individual Plan ____ Ded. $____
☐ Group R&B____

Rider/Optional Benefits

☐ Out Acc (25882) Ded. $____ Max. $____
☐ Cont Care (25883)
☐ Preg./Birth (25884) $____
☒ Amb Care (25885)
Ded. $100 Max. $1000 Coins. 80 %
☒ POV (25886) ☒ 1/16 ☐ 2/24
☒ Chemotherapy (25887)
☒ Wellness (25888)
☒ ACE (25890)
☐ ROP (25044)
☒ Air Amb (25902)
☒ R&B Enh $ 200
☐ Misc ☒ 2x ☐ 3x
☐ Surgical ☒ 2x ☐ 3x
☐ Other ____

Special Requests

Lead # 122492203 ☐ Referral 20860531000

Additional Benefits

☒ Rx Plan A ☒ Vision (25213) #____ ☐ Dental (25879)#____
☐ Acc. Med. (25315) R&B $____ Ded. $____
☐ Acc. Cat. (25314) Coins ____% Ded. $____
☐ Inc. Prot (25916) ☐ Inc. Prot Plus (25915) ☐B ☐W
Indem. Ben. $____ Elim. Per. ____days
☐ Waiv. Prem (25917) ☐ ROP (25918)
☐ Life Plan (25430) ☐ Life Plus Plan (25919)
Prim. ☐ ADB ☐ ALB Prim. DI Indem Ben $____
Sec. ☐ ADB ☐ ALB Sec. DI Indem Ben $____
☐ Primary $____ ☐ Smoker ☐ Non-Smoker
Beneficiary____ SS#____
☐ Secondary $____ ☐ Smoker ☐ Non-Smoker
Beneficiary____ SS#____

Association Membership

I am a member of the following Association: NASE
Member Level: PLATINUM PLUS Member# NEW
☐ Assoc. Advantage Card ____ Dental____

Enrollment Application for: The MEGA Life and Health Insurance Company • Oklahoma City, OK 73118

1. SCHEDULE OF FAMILY MEMBERS - FIGURE HEALTH PREMIUM AT AGE LAST BIRTHDAY

PLEASE PRINT (FULL NAME)	SEX	RELATIONSHIP	DOB	BIRTHPLACE	AGE	HEIGHT	WEIGHT	SOCIAL SECURITY #
(1) WILLIAM VERNON Meadows	M	PRIMARY	11/30/49	PELHAM, GA	55	6'00"	185	252-86-2845
(2) JEANIE LEAVERN Meadows	F	WIFE	3/15/55	GRADY, GA	46	5'04"	140	254 94 0474
(3)								
(4)								
(5)								
(6)								

Marital Status: ☐ Single ☒ Married

Applicant's Home Address:
Address 1113 OAK AVENUE
City ELBA ST AL Zip 36323
County COFFEE
Daytime Telephone (334) 897 - 8202
Home Telephone ( ) -
E-mail Address CMEADOWS@NAVER.COM
Fax Number ( ) -
Are all members U.S. Citizens? YES
If "No," please explain: ____
How long in the U.S.? ____
Occupation and duties of adult family members:
(1) MAINTENANCE AND REPAIR
(2) ____
Are all members between the ages of 19 and 24 full-time students? ____
If "Yes," name school ____
If "No," which applicant? ____
Explain ____
Is the Applicant, spouse or any dependent child (even if not proposed for insurance) now pregnant or an expectant father?
If "Yes," whom? NO
Estimated date of delivery ____
Is any Applicant eligible for or covered under Medicare or Medicaid? If "Yes," whom? NO
Do you currently have health/life insurance? NO
If "Yes," is it ___ Group or ___ Individual, names of companies, certificate/policy number, amounts and types of coverage?

Date of cancellation ____
Will existing health/life coverage be replaced or changed if proposed health/life coverage is issued? ___ Yes ___ No
If no, reason ____

10. Does any Applicant to be insured engage in any hazardous sport or activity? (e.g.: flying, diving, skydiving, racing.)
Name: NO Activity: ____
11. During the past ten years, has any person to be insured had insurance declined, rated, ridered, or otherwise changed? NO
If "Yes," which applicant ____ Date ____
Reason ____
Company ____
12. a) Applicant's Doctor DR. RUSSELL COOK
Address 207 E WATTS ST. #220
City ENTERPRISE State AL Zip 36330
Telephone Number (334) 393 - 1057
b) Spouse's Doctor DR. FERNANDEZ, JOSEPH
Address 207 WATTS STREET WEST
City ENTERPRISE State AL Zip 36330
Telephone Number (334) 393 - 8252
c) Child(ren)'s Doctor ____
Address ____
City ____ State ____ Zip ____
Telephone Number ( ) -
13. Is any member presently taking any medications? YES
a) Who? JEANIE WILLIAM
b) What? ESTRACE / ELMIRON ZESTRIL LIPITOR
c) Why? ESTROGEN BLADDER HIGH BLOOD PRESSURE, CHOLESTEROL
14. Has any applicant used tobacco products in the last 12 months? YES If "Yes," who and what? WILLIAM, SMOKE

ME000064

98-APP (9/99)

EXHIBIT C

15. Have you or any Applicant ever had your driver's license suspended, revoked or ever rece . any citations for driving while under the influence (i.e. DWI or DUI)? YES (WILLIAM)
If "Yes," list details. DWI - 1995

16. a. When was the last time the applicant visited a doctor? 2001
Symptoms? BLOOD PRESSURE Results? OK (NORMAL) Recommendations? STAY ON MEDICATION
b. When was the last time the spouse visited a doctor? 2001
Symptoms? OB/GYN VISIT Results? OK Recommendations? NONE
c. When was the last time the child(ren) visited a doctor?
Symptoms? Results? Recommendations?

17. Have you or any person to be insured EVER had symptoms, been diagnosed, received medical advice or been treated for (If "Yes," circle applicable condition):

	YES	NO
a) Heart disorder, including murmur, heart attack, chest pain, artery or vein disorder, high blood pressure or stroke?	☒	☐
b) Diabetes, hypoglycemia, goiter or thyroid disorder?	☐	☒
c) Blood or spleen disorder including anemia or leukemia?	☐	☒
d) Breast or reproductive organ disorder?	☐	☒
e) Cancer, cyst, tumor or neoplasm?	☐	☒
f) Respiratory disorder, including asthma, bronchitis, COPD, emphysema, lung disease or breathing problems?	☐	☒
g) Kidney, urinary bladder, urinary tract, stones or prostate disorders?	☒	☐
h) Stomach, intestines, gallbladder, liver or pancreas disorder including ulcer, colitis, enteritis, hepatitis or pancreatitis?	☐	☒
i) Hernia, hemorrhoids, polyps or rectal disorder?	☐	☒
j) Eye, ear, nose or throat disorders?	☐	☒
k) Skin disorders, burns, lacerations, dermatitis, boils or chronic rashes?	☐	☒
l) Back, spine, arm or leg disorder or arthritis, gout - bursitis or neuritis?	☐	☒
m) Complications of pregnancy and/or Caesarean section?	☐	☒
n) Brain disorder, epilepsy, fainting spells, dizziness, seizures, paralysis, tremors, palsy, head injury or chronic headaches?	☐	☒
o) Mental or nervous disorder, depression, anxiety, alcoholism or drug addiction?	☐	☒
p) Been diagnosed by a physician for any disorder of the blood or immune system including AIDS?	☐	☒

18. Any other medical or surgical advice, hospitalizations, treatment or operations in the last five (5) years?

19. IMPORTANT: Give complete details of any "Yes" answers to questions 17 through 18.

Name	Nature of Illness or Accident (Include Diagnosis, Operations, and Medications)	Date Started	Date Stopped	Operation	Hospitalized From/To	Doctor's Name and Address
WILLIAM	HIGH BLOOD PRESSURE meds control	1990	CURRENT	☐ Yes ☒ No	N/A	DR. GWINN - DOTHAN
JEANIE	BLADDER PROBLEM - meds control	1995	CURRENT	☐ Yes ☒ No	N/A	DR. FERNANDEZ, ENTERPRISE
WILLIAM	CHOLESTEROL (HIGH) meds control	1999	CURRENT	☐ Yes ☒ No	N/A	DR. GWINN - DOTHAN
				☐ Yes ☐ No		DR. VERNON GWINN - 1150 ROSS CLARK CIR DOTHAN, AL 36301 (334) 712-1929

Should space provided be inadequate, use separate paper to record complete information with signature of applicant.

meds control bladder problems

DECLARATIONS AND AGREEMENTS

I agree that (a) all statements and answers in this Application are true to the best of my knowledge and belief; (b) this Application will form a part of the contract; (c) the agent does not have the authority on behalf of the Company to accept the risks, or to make, alter or amend the coverage or to extend the time for making any payment due on such coverage and (d) no insurance will take effect unless and until the Application is approved by the Company and the policy/certificate is delivered to the Applicant while the conditions affecting the insurability are and have remained as described herein and the first premium has been paid in full.

INSURANCE FRAUD WARNING

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading is guilty of insurance fraud and is subject to criminal and/or civil penalties.

I have received and understand the Notification of Consumer Report and Medical Information Bureau Pre-Notice.

Signed 03 / 12 / 02 (Date) at ELBA (City), AL (State)

x [signature] Signature of Applicant

x [signature] Signature of Spouse (If to be covered)

To Be Answered By Agent:
I certify that each question on this application was asked by me of the Applicant(s) named above, and all answers are accurately recorded.

x [signature] Signature of Licensed Agent — MICHAEL JOSHUA MILFORD Print Full Name — 99EM Agent No.

25098-APP (9/99)

ME000065

(12/

The MEGA Life and Health Insurance Company

Please Read This Before Signing!

208605310003

To The Applicant:

The best business relationships are those in which there is complete and clear understanding between the parties. Accordingly, we ask that you read and sign the following statement after the representative has made a complete presentation of the plan to assure yourself that you completely understand the coverage.

CONFIRMATION OF PRESENTATION AND ACKNOWLEDGMENT OF DELIVERY AND MIB AUTHORIZATION

Attention: Underwriting Department

Upon my request, your representative, whose signature appears below, visited me to determine my interest in applying for insurance with your company. Your representative was courteous and fully and completely explained to me from the same certificate, all the provisions as contained in the certificate, including every benefit, exclusion, limitation, waiting period, and deductible, if any. Your representative asked each question on the enrollment application, which I signed only after a full review of the provisions and all the answers had been filled in. The answers to the health questions were fully answered to the best of my knowledge, and all the answers on the application are exactly those, with nothing left out, which I in any way related or stated to the representative. I fully understand and agree that if any material information is omitted from the application, it could provide the basis for the Company to refuse coverage and to refund all my premium as though my coverage had never been in force. In signing this form, I agree that I have carefully examined and understand the provisions of the specimen certificate and application, and that the Company is not bound by any knowledge of or statement made by or to the representative, unless set forth here on the application.

I understand that several deductible options are available under the plan described to me. I further understand that the larger deductible I select, the greater my out-of-pocket expenses will be as the deductible must always be satisfied by me before the Company will pay benefits.

The **Direct Benefit Plan** (Form #25874-C or its state variation) is a LIMITED BENEFIT insurance plan. It does not contain medical expense benefits. Your representative has not referred to, or represented the Direct Benefit Plan as health insurance or major medical insurance. The Direct Benefit Plan provides fixed benefits payable when Hospital Confined. You may use your benefits any way you want, including bills you may have received while Hospital confined.

I hereby authorize any licensed physician, medical practitioner, pharmacy, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any record or knowledge of me or my family, to give The MEGA Life and Health Insurance Company, or its reinsurer, any such information. The MEGA Life and Health Insurance Company may also release information about me to its reinsurer. I authorize The MEGA Life and Health Insurance Company to obtain an investigative consumer report on me. A photographic copy of this authorization shall be as valid as the original.

I understand that coverage is not effective unless and until approved and issued by the Company.

Applicant WILLIAM MEADOWS Date 03/12/02 Representative MICHAEL MILFORD # 995M

Return this form with the application.

AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORD INFORMATION

By my (our) signature(s) below, I authorize *any health care provider*, including physicians, pharmacies, clinics, hospitals or other institutions who are named in the application for insurance or who attends or has attended myself, my spouse, or any of my children, at any time, to disclose to The MEGA Life and Health Insurance Company or its legal representative, *information from my or my family's health care record.* I understand this could include, but is not limited to, my identity, medical history, diagnosis, prognosis, dates of treatment, treatment, test results, and summary reports, and this disclosure is without limitation to period of treatment, diagnostic or therapeutic information, history or type of illness including treatment, if any, for alcohol and drug abuse.

I UNDERSTAND the information obtained by use of the Authorization will be used by The MEGA Life and Health Insurance Company to determine eligibility for insurance, and eligibility for benefits under an existing policy. Any information obtained will not be released by The MEGA Life and Health Insurance Company to any person or organization EXCEPT to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required as I may further authorize.

I KNOW that I may request to receive a copy of this Authorization.
I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I AGREE this Authorization shall be valid for two years from the date shown below.
I ACKNOWLEDGE receipt of the Description of Information Practices.

I ELECT to be interviewed if an investigative consumer report is prepared in connection with this application. ☒ Yes ☐ No

Signed this 12 day of MARCH 20 02

Name of Minor Child

Signature of Proposed Insured

Name of Minor Child

Signature of Spouse

Name of Minor Child

Witness (Agent)

M/2000 APP (12/01)

ME000066

Disclosure Statemen

The LIFE Plan Insurance program is a Ten-Year Term Life Insurance Policy that is renewable to age 65. "Living Benefits" are provided by Optional Accelerated Living Benefit, and Terminal Illness Benefit Riders. Accidental Death Benefits are provided by an Optional Accidental Death Benefit Rider.

DISCLOSURE STATEMENT - ACCELERATED BENEFITS

(Complete if Accelerated Living Benefit Rider and/or Terminal Illness Rider are Selected with Life Plan)

☐ **Accelerated Living Benefit Rider:** If the Insured is diagnosed with a Heart Attack, Stroke, Coronary Artery Bypass Surgery, or Life-threatening Cancer, this rider pays 25% of the Face Amount.

☐ **Terminal Illness Rider (Accelerated Benefits):** If the Insured is diagnosed with a terminal illness that is expected to result in death in 12 months, this rider pays 50% of the Face Amount, less any benefits already paid.

Receipt of accelerated benefits may be taxable. Please consult your tax advisor regarding your tax status.

I acknowledge receipt of this Disclosure Statement regarding Accelerated Benefits. I also acknowledge receipt of a Numerical Illustration regarding the effect of the accelerated benefit on other policy/certificate values/amounts.

Signature of Proposed Insured/Applicant _____ Date _____

Signature of Agent _____ Date _____

Please complete and return if purchasing Accelerated Living Benefit Rider with the Life Plan

SUPPLEMENT TO ENROLLMENT APPLICATION

Have you or any other person applying for coverage ever had a parent, brother, or sister who had been diagnosed or treated for cancer, stroke, diabetes, heart disease or kidney disease? (if yes, complete the chart below)

YES ☐ NO ☐ (if yes, complete the chart below)

FAMILY RECORD OF PROPOSED INSURED

	Person #	Impairment	Age of Onset	Age of Death
Father				
Mother				
Brothers				
Sisters				

Signature of Proposed Insured (Primary) _____ Date _____

Signature of Proposed Insured (Spouse) _____ Date _____

Signature of Agent _____ Date _____

The MEGA Life and Health Insurance Company

THE MEGA LIFE AND HEALTH INSURANCE COMPANY

A Stock Company
(Hereinafter called: the Company, We, Our or Us)
Home Office: Oklahoma City, Oklahoma
Administrative Office: P.O. Box 982010
North Richland Hills, Texas 76182-8010
Customer Service: 1-800-527-5504

BASIC HOSPITAL/MEDICAL-SURGICAL EXPENSE CERTIFICATE

IMPORTANT NOTICE ABOUT STATEMENTS IN THE ENROLLMENT APPLICATION

The attached enrollment application is a part of this Certificate. Please read it and check it carefully. This Certificate is issued on the basis that Your answers are correct and complete. If it is not complete or has an error, please let Us know within 10 days. An incorrect enrollment application may cause Your coverage to be voided, or a claim to be reduced or denied.

10 DAY RIGHT TO EXAMINE THE CERTIFICATE

It is important to Us that You understand and are satisfied with the coverage being provided to You. If You are not satisfied that this coverage will meet Your insurance needs, You may return this Certificate to Us at Our administrative office in North Richland Hills, Texas, within 10 days after You receive it. Upon receipt, We will cancel Your coverage as of the Certificate Date, refund all premiums paid and treat the Certificate as if it were never issued.

RENEWABILITY

This Certificate is guaranteed renewable, subject to the Company's right to discontinue or terminate the coverage as provided in the TERMINATION OF COVERAGE section of this Certificate. The Company reserves the right to change the applicable table of premium rates on a Class Basis. The premium for the Certificate may change in amount by reason of an increase in the age of an Insured Person.

This Certificate is a legal contract between You and Us. **PLEASE READ YOUR CERTIFICATE CAREFULLY!**

SECRETARY PRESIDENT

IMPORTANT MESSAGE TO OUR CERTIFICATEHOLDERS

Canceling health insurance coverage and purchasing new coverage, on account of encouragement by any agent, is called replacement. Some states have laws which forbid any misrepresentation by any agent that may occur at the time of replacement. Beware of anyone who encourages You to replace this coverage without allowing You time to carefully investigate the replacement proposal, or discourages You from talking with a representative of the Company whose coverage is being recommended for replacement. For Your protection, if You are encouraged to replace this coverage, We urge You to seek advice and to take the time to investigate any recommendation.

ME000068

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CERTIFICATE SCHEDULE

COVERAGE IS PROVIDED UNDER GROUP POLICY NO.: 00384

ISSUED TO GROUP POLICYHOLDER: NASE Group Insurance Trust

PRIMARY INSURED: WILLIAM V MEADOWS

COVERED DEPENDENTS: JEANIE L

CERTIFICATE NUMBER: 053301047

CERTIFICATE DATE: 05/07/2002

INITIAL PREMIUM: $407.00

MODE OF PAYMENT: MONTHLY

SCHEDULE OF BENEFITS

LIFETIME MAXIMUM AMOUNT:		$1,000,000
AGGREGATE MAXIMUM AMOUNT:		$500,000
DEDUCTIBLE:		$2,000
BENEFITS	**Coinsurance**	**Maximum Benefit**
Hospital Room and Board Amount	100%	up to $500 per day
Hospital Intensive Care/ Cardiac Care Unit (limited to 90 days per Period of Confinement)	100%	up to $900 per day
Miscellaneous Hospital Inpatient Charges	80%	up to $12,000
Physician Visits while Hospital Confined (limited to one visit per day)	100%	up to $50 per day
Surgeon Benefit	80%	up to $12,000
Assistant Surgeon Benefit		20% of the amount paid to surgeon, up to $2,400
Anesthesiologist Benefit		30% of the amount paid to surgeon, up to $3,600
Outpatient Surgery Facility Charges	80%	up to $1,500
Ambulance Transport (payable only when Hospital Confined)	100%	up to $250 per trip
All Other Covered Expenses not Specifically listed in this Schedule of Benefits and not specifically excluded	80%	

ME000070

CERTIFICATE SCHEDULE

SCHEDULE OF BENEFITS (Continued)

RIDER BENEFITS\OPTIONAL RIDERS	Amount of Benefit
PHYSICIAN'S OFFICE VISIT BENEFIT RIDER	
Copayment, per visit	$15
Daily Maximum Benefit, per visit	$50
Maximum Number of visits	
Per Insured Person, per calendar quarter	1 visit
Per Family, per Calendar Year	16 visits
AMBULATORY CARE RIDER	
Lifetime Maximum Amount, Per Insured Person	$100,000
Deductible Per Insured Person, Per Calendar Year	$1,000
Coinsurance	80%
Maximum Benefit Amount, per Insured Person, per 24 hours	$1,000
WELLNESS RIDER	
Annual Physical Exam	
Copayment	$25
Maximum Benefit, per Calendar Year	$100
Well Child Care	
Copayment	$25
Maximum Benefit, per Calendar Year	$100
Mammograms	
Copayment	$25
Maximum Benefit, per Calendar Year	$100
AIR AMBULANCE RIDER	YES
CHEMOTHERAPY/RADIATION THERAPY RIDER	
Lifetime Maximum Amount	$100,000
Coinsurance	80%
Daily Maximum Benefit	$1,000
ACCUMULATED COVERED EXPENSE BENEFIT	
Accumulated Covered Expense Amount	$75,000
PRESCRIPTION DRUG RIDER	YES

DEFINITIONS

Aggregate Maximum Amount means the maximum amount payable under this Certificate and its Riders, if any, for any one covered Injury or Sickness for each Insured Person, occurring while coverage is in effect under this Certificate for such person. The Aggregate Maximum Amount is shown in the CERTIFICATE SCHEDULE. This amount is included in and part of the Lifetime Maximum amount for each Insured Person.

Ambulance means a ground vehicle which is licensed as required by law, as an Ambulance, and is equipped to transport Sick or Injured people.

Attained Age means the Insured Person's age on the most recent annual anniversary of the Certificate.

Calendar Year means a twelve month period which begins at 12:01 a.m. on January 1 of any year and ends at 12:00 midnight on December 31 of that year.

Certificate means the written description of coverage provided to You under the Group Policy.

Class Basis means the classification by which each Insured Person's rates are determined. We will not and cannot change the rates on this Certificate unless rates are changed on all Certificates issued on the same Class Basis.

Coinsurance means the shared percentage of Covered Expenses after satisfying the Deductible. The Coinsurance percentage We pay is shown in the CERTIFICATE SCHEDULE.

Complications of Pregnancy means:

1. Conditions requiring Hospital Confinement or treatment in an Outpatient Surgery Facility (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy, but are adversely affected by pregnancy, including but not limited to: non-elective cesarean section, acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity; or
2. Termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a time that a viable birth is not possible.

Complications of Pregnancy do not include false labor, occasional spotting, Physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication.

Confined/Confinement means an Insured Person's Medically Necessary admission to and subsequent continued stay in a Hospital or Skilled Nursing Facility as an overnight bed patient and a charge for room and board is made.

Consultation means evaluation, diagnosis, or medical advice given without the necessity of a personal examination or visit.

Cosmetic Surgery means the surgical procedures for the sole purpose of improvement of appearance, which does not effect a substantial improvement or restoration of bodily function, except:

1. Reconstructive Surgery incidental to or following Surgery resulting from trauma, infection or other disease of the involved part; or
2. Reconstructive Surgery due to a congenital disease or anomaly of a newborn child which has resulted in a functional defect.

The condition which necessitates the Surgery must occur while coverage is in force and coverage remains in force through the date of Surgery.

Covered Dependent means an Eligible Dependent whose coverage has become effective under this Certificate and has not terminated.

Covered Expenses means Usual and Customary Charges for the services, supplies, care or treatment covered under this Certificate which are incurred by an Insured Person as a result of Injury or Sickness and for which the Insured Person is legally obligated to pay and are not otherwise excluded or limited herein.

They are incurred on the date that the service is performed or the supply is furnished. Only that portion of a Usual and Customary Charge or fee which is Medically Necessary is a Covered Expense. Covered Expenses must be incurred while this coverage is in force.

Covered Expenses under the Riders, if any, may or may not be considered Covered Expenses under this Certificate.

Deductible means the amount of Covered Expenses that an Insured Person must pay for each Period of Confinement before benefits will be paid. Deductible does not include non-Covered Expenses. **The Deductible will be applied separately for each Period of Confinement in a Hospital or Outpatient Surgery Facility for each Insured Person.**

Once this Deductible has been met 3 times in a Calendar Year by any or all Insured Persons under Your Certificate, no further Deductibles must be met for the remainder of that Calendar year for any or all Insured Persons under Your Certificate.

If more than one Insured Person in Your family is injured in the same accident, only one Deductible must be satisfied for Covered Expenses associated with that accident.

Dental Care means services, supplies or other care for dental services and procedures involving tooth structures, extractions, gingival tissues, alveolar processes, dental x-rays (for other than an accidental Injury), procedures of dental origin, odontogenic cysts/tumors, or any orthodontic, periodontic, orthognathic treatment regardless of Medically Necessity. Dental care includes services and supplies for maxillary and/or mandibular augmentation/implant procedures to facilitate the use of full or partial dentures, prosthesis, fixed or removable.

Effective Date of Coverage means the date coverage becomes effective under this Certificate with respect to a particular Insured Person.

Eligible Dependent means Your lawful spouse and Your unmarried natural and adopted children and step-children who reside in your home for more than 6 months in a year, who are under 19 years of age (the Limiting Age). The Limiting Age is extended from the child's 19th birthday to the child's 24th birthday if the child is enrolled as a full-time student and attends classes regularly at an accredited college or university.

Experimental or Investigational Medicine means a drug, device or medical treatment or procedure:

1. If the drug, or device cannot lawfully be marketed without approval of the United States Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
2. If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
3. If reliable evidence shows that the consensus of opinion among experts regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence means only published reports and articles in authoritative medical and scientific literature; the written protocol or protocols by the treating facility or the protocols of another facility studying substantially the same drug, device, or medical treatment or procedures; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

Group Policyholder means the entity to which the group insurance contract ("Group Policy") is issued.

Hospital means an institution operated pursuant to its license for the care and treatment of sick and injured persons for which a charge is made that the Insured Person is legally obligated to pay. The institution must:

1. Maintain on its premises organized facilities for medical, diagnostic and surgical care for sick and injured persons on an inpatient basis;
2. Maintain a staff of one or more duly licensed Physicians;
3. Provide 24 hour nursing care by or under the supervision of a registered graduate professional nurse (R.N.); and
4. Is accredited as a Hospital by the Joint Commission on Accreditation of Hospitals.

The term "Hospital" does not include:

1. A convalescent, nursing, rest or rehabilitative facility; a home for the aged; a facility for the care and treatment of drug addicts and alcoholics; or a special ward, floor or other accommodation for convalescent, nursing, rehabilitation, ambulatory or extended care purposes; or hotel units, residential annexes or nurse administered units in or associated with a hospital; or
2. Any military or veteran's hospital, soldier's home or any hospital contracted for or operated by the Federal Government or any agencies thereof for the treatment of members or former members of the Armed Forces, unless the Insured Person is legally required to pay for services in the absence of this insurance coverage.

Immediate Family means the spouse, parent, son, daughter, brother or sister of the Insured Person.

Injury means bodily harm caused by an accident resulting in unforeseen trauma requiring immediate medical attention and is not contributed to, directly or indirectly, by a Sickness. The Injury must occur after the Insured Person's coverage has become effective and while the coverage is in force.

Insured Person means You or a Covered Dependent under this Certificate.

Intensive Care/Cardiac Care Unit means that part of a Hospital which:

1. Is segregated from the rest of the Hospital facilities;
2. Is exclusively reserved for critically ill patients who require audio-visual observation and/or cardiac monitoring as prescribed by the attending Physician; and
3. Provides room and board, specialized registered graduate professional nurses (R.N.), and special life saving equipment and supplies.

Lifetime Maximum Amount means the maximum amount payable under this Certificate and its Riders, if any, for all Covered Expenses combined, for each Insured Person. Any and all benefit amounts paid by Us will accumulate toward the Lifetime Maximum Amount from the Certificate Date. The Lifetime Maximum Amount is shown in the CERTIFICATE SCHEDULE.

Maximum Benefit means the maximum amount payable under this Certificate for each Insured Person for each Period of Confinement, unless otherwise noted on the CERTIFICATE SCHEDULE. The maximum benefit is shown in the CERTIFICATE SCHEDULE.

Medical Emergency means the sudden onset of a medical condition for which the Insured Person seeks immediate medical treatment at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe that without immediate medical attention could reasonably be expected to result in:

1. Placing the Insured Person's health in serious jeopardy;
2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Medically Necessary or Medical Necessity means that a service or supply is necessary and appropriate for the diagnosis or treatment of an Injury or Sickness based on generally accepted current medical practice. A service or supply will not be considered Medically Necessary if:

1. It is provided only as a convenience to the Insured Person or provider;
2. It is not appropriate treatment for the Insured Person's diagnosis or symptoms;
3. It exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment; or
4. It is Experimental or Investigational Medicine.

The fact that a Physician may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as amended.

Mental or Nervous Disorder means any condition or disease, regardless of its cause, listed in the most recent edition of the International Classification of Diseases as a Mental Disorder, including but not limited to neurosis, psychoneurosis, psychopathy, psychosis, bipolar Affective Disorder or Autism.

Outpatient Surgery Facility means a licensed or certified public or private medical facility:

1. With an organized staff of Physicians;
2. Which is permanently equipped and operated primarily for the purpose of performing surgical procedures; and
3. Which does not provide accommodations for overnight stays; and
4. Which provide continuous Physician services and registered professional nursing services whenever a patient is in the facility.

The term "Outpatient Surgery Facility" will include surgical suites, and facilities operated by a Hospital, which provide scheduled, non-emergency outpatient surgical care.

The term "Outpatient Surgery Facility" does not include:

1. Hospital emergency room;
2. Trauma center;
3. Physician's office (except as shown above); or
4. Clinic; or
5. Any facility that an Insured Person is admitted to as an overnight bed-patient and charged for room and board.

Period of Confinement means a period which begins on the date an Insured Person is admitted to a Hospital or Outpatient Surgery Facility for the treatment of an Injury or Sickness and ends when the Insured Person completes 180 consecutive days without being Confined in a Hospital or Outpatient Surgery Facility for the same or related cause. In no event will a single Period of Confinement exceed 365 days. A separate Period of Confinement will apply to each Injury or Sickness.

Physician means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his or her license. (A member of the Insured Person's Immediate Family will not be considered a Physician.)

Pre-Existing Condition means a medical condition, Sickness or Injury not excluded by name or specific description for which:

1. Medical advice, Consultation, or treatment was recommended by or received from a Physician within the two year period before the Effective Date of Coverage; or
2. Symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the two year period before the Effective Date of Coverage.

Sickness means an illness or disease which first manifests itself after the Insured Person's coverage becomes effective and while the coverage is in force.

Surgery means:

1. The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other invasive procedures;
2. The correction of fractures and dislocations; and
3. Any of the procedures designated by Current Procedural Terminology codes as Surgery.

Total Disability or Totally Disabled means:

1. With respect to You, You are unable to engage in any employment or occupation for which You are qualified by reason of education, training or experience and are not in fact engaged in any employment or occupation for wage or profit; and
2. With respect to any other person under the Group Policy, Confinement as a bed patient in a Hospital.

Usual and Customary Charges means charge which is the smallest of:

1. The actual charge;
2. The charge usually made for the Covered Expense by the provider who furnishes it;
3. The prevailing charge made for a Covered Expense in a geographical area by those of similar professional standing.

We, Us and Our means The MEGA Life and Health Insurance Company.

You, Your, Yours means the primary insured named in the Certificate Schedule whose coverage has become effective and has not terminated.

EFFECTIVE DATE OF COVERAGE

Beginning of Coverage

We require evidence of insurability before coverage is provided. Once We have approved Your enrollment application based upon the information You provided therein, the Effective Date of Coverage for You and those Eligible Dependents listed in the application and accepted by Us will be the Certificate Date shown in the CERTIFICATE SCHEDULE.

Newborn Children

Your newborn children will be provided coverage after the Certificate Date from the moment of birth for 31 days. Coverage for Your newborn child(ren) will not continue beyond 31 days unless You send written notice directing Us to add the newborn child(ren) to Your Certificate. This notice must be received by Us within 31 days of the newborn child's date of birth and must be accompanied by any required additional premium. A claim form or Hospital bill does not constitute written notice.

Coverage for Your newborn child(ren) will be for Sickness or Injury, including care or treatment of:

1. Congenital defects;
2. Birth abnormalities; or
3. Premature birth.

It will not include any benefits for normal newborn child care.

Additional Dependents

You may add Eligible Dependents by providing evidence of insurability satisfactory to Us and upon payment of any additional premium, if required.

The acceptance of a new Eligible Dependent and the Effective Date of Coverage for such Eligible Dependent will be shown by endorsement and the date of the endorsement.

PREMIUMS

Premium Due Date

Premiums are payable to Us at Our administrative office in North Richland Hills, Texas. The premium is payable monthly, quarterly, semi-annually or annually, as indicated in the CERTIFICATE SCHEDULE. Payment of any premium will not maintain coverage in force beyond the next premium due date, except as provided by the Grace Period. Upon the payment of a claim under this Certificate, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

Grace Period

There is a grace period of 31 days for the payment of any premiums due, except the first. At the end of the 31 day grace period, We may cancel the Certificate without further notice. During the grace period, the contract will remain in force; however, the Company is not obligated to pay any claims incurred by Insured Persons during the grace period unless and until the premium due is received during the grace period.

Premium Changes

We reserve the right to change the table of premiums, on a Class Basis, becoming due under the Group Policy at any time and from time to time; provided, We have given the Group Policyholder written notice of at least 31 days prior to the effective date of the new rates. Such change will be on a Class Basis. The premium for the Certificate may change in amount by reason of an increase in the Attained Age of the Insured Person.

TERMINATION OF COVERAGE

You

Your coverage will terminate and no benefits will be payable under this Certificate and the attached Riders, if any:

1. At the end of the period for which premium has been paid;
2. At the end of the period through which premium has been paid following Our receipt of Your written request of termination;
3. On the date of fraud or misrepresentation by You;
4. On the date We elect to discontinue this plan or type of coverage. We will give You at least 90 days notice before the date coverage will be discontinued. You will be offered an option to purchase any other coverage that We offer without regard to health status;
5. On the date We elect to discontinue all coverage in Your state. We will give You and the proper state authority at least 180 days notice before the date coverage will be discontinued; or
6. On the date an Insured Person is no longer a permanent resident of the United States.

Covered Dependents

Your Covered Dependent's coverage will terminate under this Certificate on:

1. The date Your coverage terminates;
2. The date such dependent ceases to be an Eligible Dependent;
3. The date We receive Your written request to terminate a dependent's coverage.

The attainment of the limiting age for an Eligible Dependent will not cause coverage to terminate while that person is and continues to be both:

1. Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
2. Chiefly dependent on you for support and maintenance. For the purpose of this provision "Chiefly Dependent" means the Eligible Dependent receives the majority of his or her financial support from You.

We will require that You provide proof that the dependent is in fact a disabled and dependent person at least 31 days prior to the date upon which the dependent would otherwise reach the limiting age, and thereafter we may require such proof not more frequently than annually. In the absence of such proof we may terminate the coverage of such person after the attainment of the limiting age.

Family Security Benefit

Beginning with the next premium due date following Our receipt of due proof of Your death, We will waive premiums for a period of 12 months for Your Covered Dependents. During this premium waiver period no increase in benefits or addition of Eligible Dependents, except newborns, will be considered. Provisions for termination of coverage for Covered Dependents will apply. Upon expiration of the waiver period, Your Covered Dependent spouse may continue coverage, as stated in the SPECIAL CONTINUATION PROVISION FOR DEPENDENTS by making required premium payments and by becoming a member of the association to which the Group Policy is issued.

Special Continuation Provision For Dependents

Your Covered Dependents may continue their same (or substantially similar) coverage under a new Certificate without evidence of insurability if their coverage under this Certificate would otherwise terminate because they cease to be an Eligible Dependent for any of the following reasons:

1. Divorce, legal separation, Your death; or
2. A dependent child reaches the Limiting Age.

To continue coverage, You or Your Covered Dependent must request continuation of coverage by application or written notification within 31 days of the date coverage would otherwise terminate, pay any required premium and become a member of the association to which the Group Policy is issued.

Group Policy

The Group Policyholder may terminate the Group Policy, provided written notice is given at least 31 days prior to the date of termination.

Extension of Benefits

If an Insured Person is Totally Disabled at the time the Group Policy terminates, benefits will be payable for Covered Expenses incurred due to the Injury which caused such Total Disability. Such benefits are subject to the same terms and conditions of the Group Policy if the Group Policy had remained in force. This extension of benefits will cease on the earliest of:

1. The date on which the Total Disability ceases; or
2. The end of the 90 day period immediately following the date on which the Insured Person's insurance terminated.

Reinstatement

If coverage under this Certificate terminates due to non-payment of premium, We require an application for reinstatement. The reinstatement will not become effective unless We approved such application. We will advise You of the effective date of reinstatement by giving You written notice of the date, by issuing You an amended Certificate or by issuing You a new Certificate. In any case, the reinstated coverage provides benefits only for:

1. Injury occurring after the effective date of reinstatement; and
2. Sickness first manifesting itself more than 10 days after the effective date of reinstatement.

CASE MANAGEMENT

Pre-notification Requests of Medical Non-Emergency Admissions

The Insured Person, Physician or Hospital should call the toll-free telephone number shown on Your I.D. card at least five working days prior to the planned admission.

For emergency admissions, the patient, patient's representative, Physician or Hospital should call the toll-free telephone number shown on Your I.D. card within 2 working days of the admission to provide notification of any admission due to a Medical Emergency.

IMPORTANT: Pre-notification is not a guarantee that benefits will be paid.

Case Management

Case Management authorized by Us or Our designated representative can provide reimbursement for alternative methods of care, even if the Insured Person is not covered for the alternate care or setting. Case Management is a method where We or Our designated representative will review an Insured Person's health problem and develop a plan of care that provides the most cost effective care for the Insured Person's specialized needs. The intent of Case Management is to ensure appropriate, cost effective care by extending extra-contractual benefits for alternative methods of care to Insured Persons who require the acute level of care setting. It is not designed to extend extra-contractual benefits for alternative methods of care to Insured Persons who do not meet Our standards or for services not authorized by Us or Our designated representative.

Benefits will be provided for the approved alternative methods of care only when and for so long as is determined that the alternative services are Medically Necessary and cost effective. These benefits will count toward the Insured Person's Lifetime Maximum Amount.

Our decision to implement Case Management will be made following Consultation with the affected Insured Person, or his or her legal representative, and the Insured Person's Physician.

If alternative benefits are provided for an Insured Person in one instance, it will not obligate Us to provide the same or similar benefits for any person in any other instance; nor will it be construed as a waiver of Our right to administer the Group Policy in strict accordance with its express terms.

Second Physician's Opinion

We or our designated representative may require an Insured Person to obtain a second opinion with respect to the procedures in question from a Physician selected by Us. The Insured Person must cooperate in obtaining a second opinion including any examination, testing, x-ray, or diagnostic procedures as are reasonable. There is no Coinsurance for the Physician's evaluation for the second opinion, nor for any tests needed to form the second opinion.

Pre-Admission Testing

We or Our designated representative may require that certain testing be done before admission to a Hospital.

BENEFITS

Benefits are payable under this Certificate for the following Covered Expenses. Unless otherwise stated herein, all Covered Expenses are subject to:

1. The Lifetime Maximum Amounts shown in the CERTIFICATE SCHEDULE;
2. The Deductible shown in the CERTIFICATE SCHEDULE;
3. The Coinsurance shown in the CERTIFICATE SCHEDULE;
4. The Maximum Benefit shown in the CERTIFICATE SCHEDULE;
5. The EXCLUSIONS AND LIMITATIONS; and
6. All other provisions of the Group Policy.

COVERED EXPENSES

Covered Expenses mean the Medically Necessary Usual and Customary Charges for the services, supplies, care or treatment covered under this Certificate which are incurred by an Insured Person as a result of Injury or Sickness and for which the Insured Person is legally obligated to pay. They are incurred on the date that the service is performed or the supply is furnished. Only that portion of a Usual and Customary Charge which is Medically Necessary is a Covered Expense. Covered Expenses must be incurred while this coverage is in force.

Hospital Room and Board

Covered Expenses include semi-private accommodations and general nursing care furnished by the Hospital. The charges for a private room which exceed the charges for a semi-private room are not covered unless a private room is Medically Necessary.

Hospital Intensive Care/Cardiac Care Unit

Covered Expenses include Confinement in the Hospital's intensive care or cardiac care unit. This benefit is payable in lieu of benefit amount payable for Hospital Room and Board.

Miscellaneous Hospital Inpatient Charges

Covered Expenses include all charges made by a Hospital for miscellaneous medical services and supplies necessary for the treatment of the Insured Person during that Confinement.

Covered Expenses will also include x-ray, laboratory and other diagnostic tests, services of a radiologist or radiology group and for services of a pathologist or pathology group for interpretation of diagnostic tests or studies.

The fees charged for take home drugs, personal convenience items, or items not intended primarily for use of the Insured Person while Hospital Confined are not Covered Expenses.

Physician Visits while Hospital Confined

Covered Expenses include visits by a Physician, other than the surgeon, while Hospital Confined, limited to a single Physician visit per day.

Surgeon Benefit

Covered Expenses include the Physician's charges for performing Surgery.

If two or more surgeries are performed at the same time through separate incisions, We will pay the one providing the largest benefit. We will also pay 50% of the benefits otherwise payable for the other surgeries performed at the same time.

We will not pay for more than one Surgery performed through the same incision during the same operation; however, We will pay for the Surgery providing the largest benefit.

Assistant Surgeon Benefit

Covered Expenses include the Physician's charges for assisting the Physician performing Surgery.

Anesthesiologist Benefit

Covered Expenses include the Physician's charges for providing anesthesia during Surgery.

Outpatient Surgery Facility Charges

Covered Expenses include services furnished by and supplies received for use in an Outpatient Surgery Facility, including but not limited to:

1. Use of operating room and recovery room;
2. Administration of drugs and medicines during surgery;
3. Dressings, casts, splints;
4. Diagnostic services including radiology, laboratory or pathology performed at the time of the surgery.

Ambulance Transport

Covered Expenses include ground Ambulance transportation to a Hospital, provided the Insured Person is Confined to the Hospital.

Hospital Bill Audit

If You find errors in Your medical bills, such as overcharges or charges for services not received, and have them corrected, We will pay a benefit. It will be to 50% of any savings We realize because of the resulting reduction in the amount of the Covered Expense. The maximum benefit We will pay for these cost savings is $1,000 in any one Injury or Sickness.

EXCLUSIONS AND LIMITATIONS

We will not provide any benefits for charges resulting from or in connection with:

1. Any care not Medically Necessary or charges for which benefits are not specifically provided for in this Certificate;
2. Any act of war, declared or undeclared;
3. Suicide, attempted suicide, or any intentionally self-inflicted Injury, while sane or insane;
4. Any routine physical examination, unless otherwise stated herein;
5. Any Injury or Sickness arising out of, or in the course of, employment for wage or profit, provided the Insured Person is covered under any Worker's Compensation Act, Occupational Disease Act, or similar act or law, unless the Insured Person is self-employed;
6. Mental or Nervous Disorders, unless otherwise stated herein;
7. Drug abuse or addiction including alcoholism, or overdose of drugs, narcotics, or hallucinogens, unless taken as prescribed by a Physician;
8. An overdose of drugs, being intoxicated or under the influence of intoxicants, hallucinogens, narcotics or other drugs, unless taken as prescribed by a Physician;
9. Any drug, treatment or procedure that either promotes or prevents conception or prevents childbirth, including but not limited to: (a) artificial insemination; (b) in-vitro fertilization or other treatment for infertility; (c) treatment for impotency; (d) sterilization or reversal of sterilization; or (e) abortion (unless the life of the mother would be endangered if the fetus were carried to term), unless otherwise stated herein;
10. Radial keratotomy or any eye Surgery when the primary purpose is to correct nearsightedness, farsightedness, astigmatism, or any other refractive error;
11. Spinal manipulations and manual manipulative treatment or therapy;
12. Mandibular or maxillofacial Surgery to correct growth defects after one year from the date of birth, jaw disproportions or malocclusions, or to increase vertical dimension or reconstruct occlusion;
13. Weight loss or modification, or complications arising therefrom, or procedures resulting therefrom, or for surgical treatment of obesity, including wiring of the teeth and all forms of Surgery performed for the purpose of weight loss or modification;

14. Breast reduction or augmentation unless necessary in connection with breast reconstructive Surgery following a mastectomy performed while insured under this Certificate;
15. Modification of the physical body in order to improve the psychological mental or emotional well-being of the Insured Person, such as sex-change Surgery;
16. Marriage, family, or child counseling for the treatment of premarital, marriage, family or child relationship dysfunctions;
17. Routine newborn care, unless otherwise stated herein;
18. Engaging in an illegal occupation or illegal activity;
19. Care in a nursing home, custodial institution or domiciliary care or rest cures;
20. Preparation and presentation of medical reports for appearance at trials or hearings. Physical examinations required for school events, camp, employment, licensing and insurance are expressly excluded;
21. Immunizations required for the sole purpose of travel outside of the U.S.A;
22. Payment for care for military service connected disabilities for which the Insured Person is legally entitled to services and for which facilities are reasonably available to the Insured Person and payment for care for conditions that state or local law requires be treated in a public facility;
23. Experimental medical, surgical or other health care procedures, treatments, products or services, unless otherwise stated herein;
24. Personal comfort items, such as television, telephone, lotions, shampoos, etc.;
25. Cosmetic Surgery;
26. Dental Care, treatment or Surgery unless necessitated by Injury to sound natural teeth which occurs while insured under this Certificate. (The expense must be incurred within one year from the date of Injury, and while Hospital Confined or in a Outpatient Surgery Facility);
27. Corrective vision or hearing supplies or for the examination for prescribing or fitting such supplies;
28. The removal of warts, corns, calluses, the cutting and trimming of toenails, care for flat feet, fallen arches or chronic foot strain;
29. Hernia, hemorrhoids, tonsils, adenoids, middle ear disorders, myringotomy; or any disease or disorder of the reproductive organs unless the loss is incurred 6 months after the Insured Person becomes covered under this Certificate;
30. Prescription drug benefits, unless added by rider;
31. Normal pregnancy, except for Complications of Pregnancy, unless added by Rider;
32. Treatment, services or supplies received outside the U.S. or Canada. However, benefits will be payable for Covered Expense incurred as a result of an acute Sickness or Injury sustained during the first 30 days of travel outside of the U.S. or Canada. In no event will benefits be payable beyond the first 30 days of travel outside of the U.S. or Canada; and
33. A Sickness which first manifests itself within 30 days after the Insured Person's coverage becomes effective, until coverage has been in force for a period of one year.

Pre-Existing Condition

We will not provide benefits for any loss resulting from a Pre-Existing Condition, as defined, unless the loss is incurred at least one year after the effective date of coverage for an Insured Person.

Coverage After Age 65 or Earlier Medicare Eligibility

When an Insured Person attains age 65 or becomes eligible for Medicare, whichever happens first, the benefits of this Certificate and its attachments, if any, are payable only to the extent that Covered Expenses are not paid by Medicare and they would otherwise be payable under this Certificate. The benefits will also be subject to any other EXCLUSIONS AND LIMITATIONS set forth in this Certificate.

COORDINATION OF BENEFITS

All of the benefits provided under the Group Policy are subject to this provision. However, Coordination of Benefits (COB) may not be applied to claims less than fifty dollars ($50.00). If additional liability is incurred to raise the claim above fifty dollars ($50.00), the entire liability may be included in the COB computation.

Plan means any plan providing benefits or services for or by a reason of expenses incurred for hospital, medical, or dental care or treatment, which benefits or services are provided by:

1. Group, association group, or blanket insurance coverage;
2. Group Blue Cross, Blue Shield or other prepayment coverage provided on a group basis;
3. Any coverage under labor-management trustee plans; union welfare plans, self-funded plans, employer organization plans, employee benefit organization plans or any other arrangement of benefits for individuals of a group; any coverage under governmental programs, except Medicaid, and any coverage required or provided by any statute, including no-fault auto insurance.

The term "Plan" shall be construed separately with respect to each policy, contract or other arrangement for benefits or services and separately with respect to that portion of such policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

This Plan refers to provisions of the Group Policy which are subject to this section.

Allowable Expense will be any necessary, Usual and Customary Charge, all or part of which is covered by at least one of the Plans covering the Insured Person. Allowable Expenses to a "secondary" plan will include the value or amount of any deductible amount or co-insurance percentage or amount of otherwise Allowable Expenses which is not paid by the "primary" or first paying plan.

Some plans provide benefits in the form of services rather than cash payments. For those plans, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

Claim Determination Period is a Calendar Year or portion thereof during which the Insured Person has been covered under This Plan.

Determination of benefits payable under This Plan and all other applicable Plans will be controlled by this provision, if without this provision the sum of the benefits payable under:

1. This Plan; and
2. All other applicable plans,

would exceed the Allowable Expense.

If the sum of 1. and 2. above does exceed the total Allowable Expense, benefits payable under This Plan will be reduced by the amount of benefits payable under all other Plans.

Benefits of any other Plans which contain a COB provision will be ignored when computing the benefits of This Plan if:

1. The other plan's COB provision states that the benefits will be determined after This Plan computes its benefits; and
2. The rules set forth below would require This Plan to compute its benefits first.

The rules that set the order of benefit determination are:

1. A plan that covers the Insured Person other than as a dependent will compute benefits before a plan that covers the Insured Person as a dependent; and
2. When a dependent is a child covered under separate plans of each parent, the plan covering the parent whose date of birth (month and day) precedes the other in the Calendar Year shall be primary; except:
   a) where both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time; or
   b) where the parents are separated or divorced and the parent with custody of the child has not remarried, then the plan covering the parent with custody shall be primary; or
   c) where the parents are divorced and the parent with custody of the child has remarried; then: (i) the plan covering the parent with custody shall be primary, or (ii) the plan covering the step-parent of the child shall be primary to that of the parent without custody; or

d) notwithstanding subparagraphs a), b), and c) above, where the parents are divorced or separated and there is a court decree establishing the financial responsibility of medical or other health care expenses with respect to the child of one parent, then the plan covering the parent with the financial responsibility shall be primary; and

3. If benefit determination order is not established above, the primary plan is the plan which has been in effect the longest except:

   a) if plan benefits of the Insured Person are based on a laid-off, or retired employee or a dependent of either, then that plan will be secondary to the other plan's benefits. If neither plan has a provision for a laid-off, or a retired employee or a dependent of either and each plan determines benefits after the other, then this subparagraph a) is not applicable.

We reserve the right to release or obtain information that We deem necessary, about any person to or from:

1. Any other insurance company; or
2. Any organization or person.

At Our request, the Insured Person shall furnish us with any information needed to determine payment of benefits under this COB provision.

Facility of Payment

Whenever benefits which should have been paid under This Plan are paid under any other Plan, We shall have the right to pay to the organization that made the payments any amount that We feel will satisfy this provision. Amounts so paid will be deemed benefits paid under This Plan and We will be fully discharged from liability under This Plan.

Right of Recovery

If We, at any time, pay the total Allowable Expense and that amount exceeds the payment required to satisfy the intent of this provision, We will have the right to recover such payments, to the extent of such excess, from among one or more of the following, as We shall determine: any persons to or for or with respect to whom such payments were made; any other insurance companies; any other organization.

Time Limit for Payment

Payment of benefits must be made within thirty (30) calendar days after submittal of a proof of loss, unless We provide the claimant a clear and concise statement of a valid reason for further delay which is in no way connected with or caused by the existence of this COB provision nor otherwise attributable to Us.

GENERAL PROVISIONS

Entire Contract

The Entire Contract consists of:

1. The Group Policy, which includes this Certificate;
2. The application of the Group Policyholder, which will be attached to the Group Policy;
3. Any enrollment applications for the proposed insured individuals; and
4. Any endorsements, amendments or riders attached.

All statements made by the Group Policyholder or by You will, in the absence of fraud, be deemed representations and not warranties.

Only Our President, a Vice President or Secretary has the power on Our behalf to execute or amend the Group Policy. No other person will have the authority to bind Us in any manner. No agent may accept risks, alter or amend coverage or waive any provisions of the Group Policy. Any change in the Group Policy will be made by amendment approved by the Group Policyholder and signed by Us. Such amendment will not require the consent of any Insured Person.

Notice of Claim

Written notice of claim must be given to Us within 20 days, or as soon as reasonably possible. Written notice of claim given by or on behalf of the Insured Person to Us with information sufficient to identify such person will be considered notice to Us.

Claim Forms

When We receive the notice of claim, We will send the Insured Person forms for filing proof of loss. If these forms are not furnished within 15 days, the Insured Person will meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the next provision.

Proof of Loss

Written proof of loss must be furnished to Us at Our administrative office in North Richland Hills, Texas, within 90 days after the date of the loss for which claim is made. Failure to furnish written proof of loss within that time will neither invalidate nor reduce any claim if it is shown that it was not reasonably possible to furnish written proof of loss within that time; provided such proof is furnished as soon as reasonably possible and in no event, in the absence of legal incapacity, later than one year from the time proof is otherwise required.

Claim Payments

We will pay all benefits due under the Group Policy promptly upon receipt of due proof of loss.

All benefits are payable to You, however, at Our Option, We may pay the provider of service instead, unless You have requested otherwise in writing prior to providing proof of loss. If any such benefits remain unpaid at Your death, or if You are, in Our opinion, incapable of giving a legally binding receipt for payment of any benefit, We may, at Our option, pay such benefit to Your estate or any one or more of the following relatives: Your spouse; mother, father, child or children; brother or brothers; sister or sisters. Any payment so made will constitute a complete discharge of Our obligations to the extent of such payment.

Physical Examination

We will, at Our own expense, have the right and opportunity to examine the Insured Person whose Injury or Sickness is the basis of a claim when and as often as We may reasonably require during the pendency of a claim and to make an autopsy in case of death, unless prohibited by law.

Legal Action

No action at law or in equity will be brought to recover on the Group Policy prior to the expiration of 60 days after proof of loss has been filed as required by the Group Policy; nor may any action be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

Age Misstatement

If the age of any Insured Person has been misstated, Our records will be changed to show the correct age. The benefits provided will not be affected if the Insured Person continues to be eligible for coverage at the correct age. However, premium adjustments, including collection of any premium due Us because of past underpayments, will be made so that We receive the premiums due at the correct age payable on the premium due date following Our notification of an age correction.

Incontestability

After 2 years from the Insured Person's Effective Date of Coverage, no misstatements, except fraudulent misstatements, made in the enrollment application will be used to void the coverage, or deny a claim unless the loss was incurred during the first 2 years following such Insured Person's Effective Date of Coverage.

No claim for a loss incurred one year after an Insured Person's Effective Date of Coverage will be reduced or denied as a Pre-Existing Condition.

Conformity

Any provision of this Certificate which, on the Effective Date of Coverage, is in conflict with the extraterritorial statutes of the state in which You reside on such date, is hereby amended to conform to the minimum requirements of such statutes.

Change of Residence

If You move, You must notify the Company. Only the extraterritorial benefits mandated by the State in which You reside will be considered Covered Expenses under this Certificate. An Insured Person must be a permanent resident of the United States in order to remain eligible for insurance under this Certificate.

Subrogation

You agree that We shall be subrogated to Your right to damages, to the extent of the benefits provided by the Certificate, for Injury or Sickness that a third party is liable for or causes. You agree to repay Us first out of any monies You obtain regardless of the amount that You recover. In the event that We retain Our own attorney to represent Our subrogation interest, We will not be responsible for paying a portion of Your attorney fees or costs.

You assign to Us Your claim against a liable party to the extent of Our payments, and shall not prejudice Our subrogation rights. Entering into a settlement or compromise arrangement with a third party without Our prior written consent shall be deemed to prejudice Our rights. You shall promptly advise Us in writing whenever a claim against another party is made and shall further provide to us such additional information as is reasonably requested by Us. You agree to fully cooperate in protecting Our rights against a third party.

Right of Reimbursement

You may receive benefits under the Group Policy, and may also recover losses from another source, including Workers' Compensation, uninsured, underinsured, no-fault or personal injury protection coverages. The recovery may be in the form of a settlement, judgement, or other payment.

You must reimburse Us from these recoveries in an amount up to the benefits paid by Us under the Group Policy. You agree to repay us first out of any monies You obtain regardless of the amount that You recover. We have an automatic lien on any recovery.

THE MEGA LIFE AND HEALTH INSURANCE COMPANY

A Stock Company
(Hereinafter called: the Company, We, Our or Us)
Home Office: Oklahoma City, Oklahoma
Administrative Office: P.O. Box 982010
North Richland Hills, Texas 76182-8010
Customer Service: 1-800-527-5504

WELLNESS RIDER

This Rider is made a part of the Group Policy and Certificate to which it is attached. The Rider is subject to all provisions, terms, DEFINITIONS and EXCLUSIONS AND LIMITATIONS of the Group Policy and Certificate which are not inconsistent with the provisions of this Rider.

The benefits provided by this Rider will not duplicate the benefits provided under the Certificate and any other rider and are subject to the maximum benefits and Copayment shown for this Rider in the CERTIFICATE SCHEDULE.

Benefits payable under this Rider are not subject to the Certificate Deductible.

BENEFITS

We will pay benefits for the following preventive health care services incurred by an Insured Person, while this Rider is in force:

1. Annual health assessments, including but not limited to, physical examinations, blood pressure, height and weight measurement, provided such services are incurred after this Rider has been in force for at least 12 months;
2. Low-Dose Mammography Screening for women, as follows:
   a) one baseline mammogram for women age 35 to 39;
   b) a screening not less than once every 2 years for women age 40 to 49; and
   c) an annual screening for women age 50 and over;
3. Pediatric/juvenile well child care through age 18, including routine immunizations.

Low-Dose Mammography Screening means the x-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the x-ray tube, filter, compression device, screens, and films and cassettes, within an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.

We will provide this benefit in consideration of the payment of the required premium for this Rider.

Rider effective date, if different from Certificate Date: _____

THE MEGA LIFE AND HEALTH INSURANCE COMPANY

SECRETARY

PRESIDENT

THE MEGA LIFE AND HEALTH INSURANCE COMPANY

A Stock Company
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North Richland Hills, Texas 76182-8010
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AIR AMBULANCE RIDER

This Rider is made a part of the Group Policy and Certificate to which it is attached. The Rider is subject to all provisions, terms, DEFINITIONS and EXCLUSIONS AND LIMITATIONS of the Group Policy and Certificate which are not inconsistent with the provisions of this Rider.

The benefits provided by this Rider will not duplicate the benefits provided under the Certificate and any other rider.

COVERED EXPENSES

We will pay benefits for Covered Expenses of an Insured Person while this Rider is in force for Air Ambulance transportation to the nearest available medical facility that can provide adequate care in the event of a Medical Emergency, as defined in the Certificate. Air Ambulance transportation is payable under this Rider at a base rate of $1500, plus an additional $20 per mile, up to a maximum benefit of $3500 per Calendar Year.

This benefit is payable only if:

1. the Insured Person requires an advanced level of care during transportation; and
2. the potential delays which may be associated with ground transportation, including road conditions and traffic, could jeopardize the Insured Person's condition.

Air Ambulance means a privately or publicly owned aircraft appropriately licensed by the state where the service originated, that is designed and used to provide air transport of persons suffering from a Sickness or Injury and that contains all life-saving equipment and staff as required by state and local law.

Covered Expenses incurred under this Rider will not be used to satisfy the Certificate Deductible.

We will provide this benefit in consideration of the payment of the required premium for this Rider.

Rider effective date, if different from Certificate Date: _____

THE MEGA LIFE AND HEALTH INSURANCE COMPANY

Peggy G Simpson
Secretary

Chuck T. Pruett
President

ME000088

25902

CMRXX109001

THE MEGA LIFE AND HEALTH INSURANCE COMPANY

A Stock Company
(Hereinafter called: the Company, We, Our or Us)
Home Office: Oklahoma City, Oklahoma
Administrative Office: P.O. Box 982010
North Richland Hills, Texas 76182-8010
Customer Service: 1-800-527-5504

AMBULATORY CARE RIDER

This Rider is made a part of the Group Policy and Certificate to which it is attached. The Rider is subject to all provisions, terms, DEFINITIONS and EXCLUSIONS AND LIMITATIONS of the Group Policy and Certificate which are not inconsistent with the provisions of this Rider.

The benefits provided by this Rider will not duplicate the benefits provided under the Certificate and any other rider and are subject to the maximum benefit amount and Coinsurance, the deductible and the Lifetime Maximum Benefit Amount shown for this Rider in the CERTIFICATE SCHEDULE.

COVERED EXPENSES

We will pay benefits for Covered Expenses incurred by an Insured Person, while this Rider is in force, for:

1. Diagnostic x-rays and interpretations charges;
2. Laboratory and pathological examinations, and
3. Physical, Occupational, Speech Therapy (preceded by Hospital Confinement or Surgery and not received during Hospital Confinement);

while not Confined to a Hospital and that are related to and necessary for the diagnosis and treatment of a Sickness or Injury. Benefits under this Rider include, but are not limited to, Covered Expenses incurred for:

CAT Scans
Mammograms
Electrocardiogram (EKG)
Angiogram
Magnetic Resonance Imaging (MRI)
Upper/Lower G.I. Series
Blood or serum analysis
Stress Tests

LIMITATIONS AND EXCLUSIONS

In addition to the EXCLUSIONS and LIMITATIONS of the Certificate, We will not pay benefits under this Rider for:

1. Physician's office visit or clinic charges, Hospital emergency room charges, Outpatient facility charges, Outpatient Surgery Facility charges or any other facility charges associated with the above Covered Expenses;
2. Pre-Existing conditions;
3. Physical examinations or checkups;
4. Prescription drugs and medicines;
5. Radiation or chemotherapy for the purpose of modification or destruction of cancerous tissue;
6. Any test, procedures or services related to pregnancy or childbirth unless Medically Necessary due to Complications of Pregnancy, as defined in the Certificate.

Covered Expenses incurred under this Rider will not be used to satisfy the Certificate Deductible.

We will provide this benefit in consideration of the payment of the required premium for this Rider.

Rider effective date, if different from Certificate Date:_____

THE MEGA LIFE AND HEALTH INSURANCE COMPANY

SECRETARY

PRESIDENT

THE MEGA LIFE AND HEALTH INSURANCE COMPANY

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PHYSICIAN OFFICE VISIT BENEFIT RIDER

This Rider is made a part of the Group Policy and Certificate to which it is attached. The Rider is subject to all provisions, terms, DEFINITIONS and EXCLUSIONS AND LIMITATIONS of the Group Policy and Certificate which are not inconsistent with the provisions of this Rider.

The benefits provided by this Rider will not duplicate the benefits provided under the Certificate and any other rider and are subject to the maximum benefits and Copayments shown for this Rider in the CERTIFICATE SCHEDULE.

Benefits payable under this Rider are not subject to the Certificate Deductible.

COVERED EXPENSES

We will pay Covered Expenses incurred by an Insured Person, while this Rider is in force, for Medically Necessary visits to the Physician's office or clinic and for related care services provided by the Physician as a part of such visit, up to the Daily Maximum Benefit subject to the Copayment shown in the CERTIFICATE SCHEDULE. No benefits are payable for services such as routine examinations, immunizations, and preventive care.

Copayment means the amount the Insured Person is required to pay for specifically listed Covered Expenses. The Copayment for this Rider is shown in the CERTIFICATE SCHEDULE. Copayments do not count toward Deductibles or Coinsurance Maximums.

Benefits payable under this Rider will not be used to satisfy the Certificate Deductible.

We will provide this benefit in consideration of the payment of the required premium for this Rider.

Rider effective date, if different from Certificate Date: _____

THE MEGA LIFE AND HEALTH INSURANCE COMPANY

SECRETARY

PRESIDENT

ME000091

THE MEGA LIFE AND HEALTH INSURANCE COMPANY

A Stock Company
(Hereinafter called: the Company, We, Our or Us)
Home Office: Oklahoma City, Oklahoma
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North Richland Hills, Texas 76182-8010
Customer Service: 1-800-527-5504

CHEMOTHERAPY AND RADIATION THERAPY RIDER

This Rider is made a part of the Group Policy and Certificate to which it is attached. The Rider is subject to all provisions, terms, DEFINITIONS and EXCLUSIONS AND LIMITATIONS of the Group Policy and Certificate which are not inconsistent with the provisions of this Rider.

The benefits provided by this Rider will not duplicate the benefits provided under the Certificate and any other rider and are subject to the Daily Maximum Benefits, Coinsurance and the Lifetime Maximum Benefit Amount shown for this Rider in the CERTIFICATE SCHEDULE.

Benefits payable under this Rider are not subject to the Certificate Deductible.

COVERED EXPENSES

We will pay benefits for Covered Expenses incurred by an Insured Person, while this Rider is in force, for Chemotherapy and Radiation Therapy. The condition for which Chemotherapy or Radiation therapy is provided must be first diagnosed and the treatment must be received while coverage is in force under this Rider.

All Covered Expenses payable under this Rider are paid in lieu of Covered Expenses incurred under the Certificate and will not be used to satisfy the Certificate Deductible.

We will provide this benefit in consideration of the payment of the required premium for this Rider.

Rider effective date, if different from Certificate Date: _____

THE MEGA LIFE AND HEALTH INSURANCE COMPANY

SECRETARY

PRESIDENT

THE MEGA LIFE AND HEALTH INSURANCE COMPANY

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ACCUMULATED COVERED EXPENSE RIDER

This Rider is made a part of the Group Policy and Certificate to which it is attached. The Rider is subject to all provisions, terms, DEFINITIONS and EXCLUSIONS AND LIMITATIONS of the Group Policy and Certificate which are not inconsistent with the provisions of this Rider.

Once an Insured Person's Covered Expenses under the Certificate total the Accumulated Covered Expense Amount shown in the CERTIFICATE SCHEDULE during a Period of Confinement (regardless of the maximum benefit limits shown in the CERTIFICATE SCHEDULE), Covered Expenses incurred during the remainder of that Period of Confinement will be paid at 100% up to the Aggregate Maximum Amount shown in the CERTIFICATE SCHEDULE.

We will provide this benefit in consideration of the payment of the required premium for this Rider.

Rider effective date, if different from Certificate Date:_____

THE MEGA LIFE AND HEALTH INSURANCE COMPANY

SECRETARY

PRESIDENT

ME000093

THE MEGA LIFE AND HEALTH INSURANCE COMPANY

A Stock Company
(Hereinafter called: the Company, We, Our or Us)
Home Office: Oklahoma City, Oklahoma
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North Richland Hills, Texas 76182-8010
Customer Service: 1-800-527-5504

LEGEND PRESCRIPTION DRUG EXPENSE RIDER

This Rider is made a part of the Group Policy and Certificate to which it is attached. The Rider is subject to all provisions, terms and DEFINITIONS of the Group Policy and Certificate which are not inconsistent with the provisions of this Rider.

The benefits provided by this Rider will not duplicate the benefits provided under the Certificate and any other rider and are subject to the maximum benefit amount and deductible stated herein.

BENEFITS

If an Insured Person incurs Covered Expenses for Sickness or Injury, We will pay a benefit. This benefit is the amount equal to the actual charge based on Participating Pharmacy prices for a Covered Expense, subject to the applicable Benefit Payment Rate/Deductible/Copayment shown below. Expenses are considered incurred on the date of Pharmacy service.

You have the option to receive drugs either retail or through Our Mail Service Legend Prescription Drug Program.

BENEFIT PAYMENT RATE/DEDUCTIBLE/COPAYMENT

BENEFIT PAYMENT RATE/DEDUCTIBLE/COPAYMENT
A Deductible of $50 will apply each Calendar Year to each Insured Person. After the Deductible is met, We will pay benefits subject to the applicable Benefit Payment Rate and Copayment specified below.

Participating Pharmacy	
Generic Drugs (not to exceed a 30 day supply)	100% less the $10.00 Copayment
Brand Name Drugs (not to exceed a 30 day supply)	25% discount
Non-Participating Pharmacy	0%
Mail Service Legend Prescription Drugs	
(Not to exceed a 90 day supply through Our designated mail service program)	
Generic Drugs	100% less the $10.00 Copayment
Brand Name Drugs	25% discount
Benefit Maximum	
Per Insured Person	$1,000 per calendar year

ME000094

LEGEND PRESCRIPTION DRUGS FROM A PARTICEPATING/MAIL ORDER VENDOR:

1. If You have a prescription filled with a generic drug, You must pay the Pharmacy the Copayment amount set forth above for each separate prescription or refill for that generic drug. The Pharmacy will be paid directly by Us for the remainder of the cost of the prescription or refill.

2. If You have the prescription filled with a brand name drug, You must pay the Pharmacy the Copayment amount set forth above for each separate prescription or refill for that brand name drug. The Pharmacy will be paid directly by Us for the remainder of the cost of the prescription or refill.

3. If You have a prescription filled with a brand name drug, and there is a therapeutic generic equivalent drug for that brand drug, We have special payment rules regarding reimbursement when a therapeutic generic equivalent drug could have been prescribed. We have created a list of generic drugs that the FDA has categorized as therapeutic equivalents to the corresponding brand name drug.

   Our payment will be based on the therapeutic generic equivalent drug fee schedule, which We have created for these therapeutic generic equivalent drugs or the actual drug charge, whichever is less. **You will be responsible for the generic drug Copayment set forth above and the difference in cost between Our payment and the actual cost of the brand name drug.**

   For example, assume You have a prescription for a brand name drug that costs $100, and the therapeutic equivalent generic has a fee schedule of $25. We will pay the $25, less the applicable Copayment amount ($10.00). **You must pay the generic drug Copayment amount plus the $75 balance remaining on the $100 charge.**

DEFINITIONS

Copayment means the amount which may be charged to the Insured Person by the Pharmacy for the dispensing, including each refill, of any Legend Prescription Drug, before We will make any payments under this Rider.

Deductible means the amount of Covered Expenses that an Insured Person must pay each calendar year before benefits will be paid. The Deductible does not include non-Covered Expenses.

Covered Expense means the actual charges for:

1. Legend Prescription drugs.
2. Compounded medication of which at least one ingredient is a Legend Prescription Drug.
3. Any other drug which, under the applicable state law, may be only dispensed upon written prescription of a Physician or other lawful prescriber.

Legend Prescription Drugs mean drugs, devices, biological and compounded prescriptions which can be dispensed only pursuant to a prescription; which by law are required to bear the legend "Caution - Federal Law prohibits dispensing without a prescription." The drug or device must be prescribed by an Insured Person's Physician or other licensed/authorized health care provider, and approved by the FDA for the treatment of the Insured Person's specific diagnosis or condition or recognized for treatment of that indication in one of the standard reference compendia, or in scientific studies published in any peer-reviewed national professional journal.

In certain situations, specific criteria including Medical Necessity criteria, may be established by Us and Our provider community, which defines whether certain drugs will be covered under this Rider.

We reserve the right to require prior authorization for any drug prior to payment under this Rider. You may call Us if You wish to obtain a list of drugs which require prior authorization.

Non-Participating Pharmacy means any Pharmacy which regularly dispenses Legend Prescription Drugs and has not entered into a Participation Agreement with Us. We will not pay for any benefits under this Rider for drugs that are purchased at a Non-Participating Pharmacy located in Our Provider Network Area.

Participating Pharmacy means any Pharmacy which regularly dispenses Legend Prescription Drugs and has entered into a Participation Agreement with Us.

Pharmacy means a facility where the practice of Pharmacy occurs.

Prescription Order means the request for a drug or device issued by a Physician or other qualified provider duly licensed to make such a request in the ordinary course of his/her professional practice.

EXCLUSIONS

We will not provide any benefits for:

1. Expenses incurred after coverage terminates under this Rider;
2. Non-legend drugs;
3. Insulin, insulin syringes, needles and other diabetic supplies;
4. Devices of any type, even though such devices may require a Prescription Order, such as, but not limited to, contraceptive devices, therapeutic devices, artificial appliances, hypodermic needles, syringes, support garments, ostomy supplies, and other non-medical substances, or similar devices, regardless of intended use;
5. Contraceptives, oral or other, whether medication or device, regardless of intended use;
6. Immunization agents, allergy sera, biological sera, blood or blood products administered on an outpatient basis;
7. Anti-smoking aids (e.g. nicorette gum, nicotine patches);
8. Drugs labeled, "Caution - limited by federal law to Investigational use" or Experimental drugs, even though a charge is made to the Insured Person;
9. Products used for unapproved cosmetic indications;
10. Any illegal substance;
11. Drugs used to treat or cure baldness, and anabolic steroids used for body building;
12. Any charge for the administration of Legend Prescription Drugs or injectable insulin;
13. Drugs for participants covered under Medicare or Medicaid programs, or drugs paid by or covered under any benefit or insurance program;
14. Non-injectable vitamins or fluorides or health foods, health and beauty aids, cosmetics, nutritional or dietary supplements;
15. Drugs determined to be "less than effective" by the Drug Efficacy Study Implementation (DESI) Program. For example: Equagesic, Midrin, Cyclospasmol, and Vasodilan have been rated less-than-effective. The Omnibus Budget Reconciliation Act of 1981 has mandated the Health Care Financing Administration to ban reimbursement for less-than-effective drugs products by federal Medicare/Medicaid agencies;
16. Any medication, legend or not, which is consumed or administered at the place where it is dispensed;
17. Anorectic, Weight control drugs; or
18. Fertility drugs.

LIMITATIONS

The following dispensing limits apply to each prescription:

1. **Participating Pharmacy** - No more than a 30 day supply or 100 unit doses, whichever is less, may be dispensed. No more than two refills of the same prescription may be dispensed in any one calendar year. For certain drugs, less than a 30 day supply or 100 unit doses may be dispensed.

2. **Mail Service Legend Prescription Drugs** - No more than a 90 day supply may be dispensed at any one time. For certain drugs, less than a 90 day supply may be dispensed.

We will provide this benefit in consideration of the payment of the required premium for this Rider.

Rider effective date, if different from Certificate Date: _____

THE MEGA LIFE AND HEALTH INSURANCE COMPANY

SECRETARY

PRESIDENT

ME000097

The MEGA Life and Health Insurance Company
A Stock Company
(Hereinafter called: the Company, We, Our or Us)
Home Office: Oklahoma City, Oklahoma
Administrative Office: P.O. Box 982010
North Richland Hills, Texas 76180-5605
Customer Service: 1-800-527-5504

AMENDATORY ENDORSEMENT

This Amendatory Endorsement is made a part of the Group Policy and Certificate to which it is attached. It is subject to all the provisions of the Group Policy which are not inconsistent with this endorsement. It is applicable only to Insured Persons who are residents of the State of Alabama.

1. The following definitions under the **DEFINITIONS** section are hereby deleted and replaced with the following:

   - **Eligible Dependent** means Your lawful spouse and Your unmarried natural and adopted children and step-children who are under 19 years of age (the Limiting Age). The Limiting Age is extended from the child's 19th birthday to the child's 24th birthday if the child is enrolled as a full-time student and attends classes regularly at an accredited college or university.

   - **Pre-Existing Condition** means a Medical Condition, Sickness or Injury not excluded by name or specific description for which:
     1. Medical Advice, Consultation, or Treatment was recommended by or received from a Physician within a one year period prior to the Effective Date of Coverage; or
     2. Symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the one year period before the Effective Date of Coverage.

2. The following Covered Expenses are added to the BENEFITS section. Unless otherwise stated, all Covered Expenses are subject to the Deductible, Coinsurance and Lifetime Maximum Amount shown in the CERTIFICATE SCHEDULE; the Maximum Benefit, Benefit and/or Aggregate Maximum Amounts, if any, shown in the CERTIFICATE SCHEDULE; and the Coinsurance Maximum and Copayments, if any, shown in the CERTIFICATE SCHEDULE. Unless otherwise stated, these Covered Expenses are also subject to the EXCLUSIONS AND LIMITATIONS and all other provisions of the Group Policy:

   - **Mammography Screening**

   Covered Expenses include charges for Mammography Screening for the presence of breast cancer for an insured adult female at the following age intervals:
   1. A single mammography screening once every two years for women ages forty (40) to forty-nine (49), unless Your Physician determines, due to certain risk factors, that a mammography screening is required more often; and
   2. A single mammography screening once per calendar year for women age fifty (50) and older, unless Your Physician determines, due to certain risk factors, that a mammography screening is required more often.

   - **Minimum Stay Requirements For Covered Maternity Care**

   This provision applies to an Insured Person's coverage only when the Insured Person incurs Covered Expenses for a normal childbirth or cesarean section delivery that is covered by an optional Maternity Benefit Rider or for Complications of Pregnancy as defined in the Certificate. A minimum of 48 hours of inpatient care will be provided to the mother and newborn child following a vaginal delivery and 96 hours following a cesarean section. Any normal childbirth delivery is subject to the Maximum Benefit for Pregnancy/Childbirth as stated in the optional Maternity Benefit Rider.

3. The first paragraph in the **Claim Payments** and **Subrogation** provisions under the **GENERAL PROVISIONS** section are hereby deleted and replaced as follows:

- **Claim Payments**

  We will pay all benefits due under the Group Policy no later than 25 days from receipt of due proof of loss. If reimbursement is not made within 25 days from receipt of due proof of loss, starting on the 26th day, interest at the rate of 1.5% per month or any part of a month thereof will accrue until the claim is paid. If we contest a claim, written notice will be supplied no later than two weeks from receipt of due proof of loss.

- **Subrogation**

  You agree that We shall be subrogated to any Insured Person's right to damages, provided such Insured Person has been made whole, to the extent of the benefits provided by the Certificate, for Injury or Sickness that a third party is liable for or causes. In the event that We retain Our own attorney to represent Our subrogation interest, We will not be responsible for paying a portion of Your attorney fees or costs.

In Witness Whereof, the Insurance Company has caused this Amendment to be signed by its President and Secretary.

Signed for The MEGA Life and Health Insurance Company at North Richland Hills, Texas.

Secretary

President

ME000099

INSURANCE CENTER

Please complete the appropriate areas for changes to your coverage.

NAME: WILLIAM V MEADOWS (Primary Member) Certificate/Policy Number 053301047

☐ **1. Change Mailing Address To:**

_____ Phone# Work: (__) _____
No. Street City State Zip

Email Address: _____ Phone# Home:(__) _____

☐ **2. Change of Dependents:** (✓ D for Delete and A for Add. Complete Enrollment Application for additions, unless newborn child within 30 days of birth).

A	D	Full Name	Sex	Age	Date of Birth
☐	☐				
☐	☐				
☐	☐				
☐	☐				

☐ **3. Provider Network Directory - Please refer to the back of ID Cards for web site.**
Check the appropriate box:

☐ Please send a **Personalized** Directory.

☐ Please send a **State Wide** Directory.

☐ **4. Additional I.D. Cards**

☐ **5. Other:**

I understand the Company may find it necessary to amend this form in order to comply with Company practices or Certificate/Policy provisions. I therefore agree that my acceptance of the Certificate/Policy, modified by my request as amended, shall constitute my approval.

Dated at _____ this ___ day of _____, 20____
(City) (State)

Signature of Primary: _____ Signature of Spouse: _____

Mail to: Customer Service Department
9151 Grapevine Highway
P.O. Box 982010
North Richland Hills, TX 76182-8010

ME000100

XXXXX17001

CF-6/00

The MEGA Life and Health Insurance Company
Insurance Center
P.O. Box 982009 North Richland Hills, TX 76182-8009

We want to pay your claim promptly. You can help by printing clearly with a black pen.

CLAIMANT'S STATEMENT

PRIMARY INSURED	HEALTH ID NUMBER	TELEPHONE NUMBER
WILLIAM V MEADOWS	053301047	( )

ADDRESS	CITY	STATE	ZIP

PATIENT'S NAME (IF A DEPENDENT)	DEPENDENT'S DATE OF BIRTH

DOES THE PATIENT HAVE ANY OTHER HEALTH INSURANCE? YES ☐ (IF YES, COMPLETE THE FOLLOWING) NO ☐

NAME OF EMPLOYER/POLICY HOLDER	POLICY NUMBER	EFFECTIVE DATE

NAME OF OTHER INSURANCE COMPANY — GROUP [ ] OR INDIVIDUAL [ ]

OTHER INSURANCE COMPANY LOCAL CLAIM OFFICE ADDRESS	CITY	STATE	ZIP

ARE YOU RECEIVING OR APPLYING FOR WORKMEN'S COMPENSATION? YES ☐ NO ☐

COMPLETE THIS SECTION IF CLAIM IS DUE TO AN ILLNESS

DATE ILLNESS BEGAN	DATE OF FIRST TREATMENT	TREATED BY WHOM/WHERE

DESCRIBE ILLNESS

COMPLETE THIS SECTION IF CLAIM IS DUE TO AN ACCIDENT

DATE OF ACCIDENT	DATE OF FIRST TREATMENT	DESCRIBE HOW, WHEN, AND WHERE ACCIDENT OCCURRED

COMPLETE THIS SECTION IF YOU WERE CONFINED TO A HOSPITAL

NAME OF HOSPITAL	DATE ADMITTED	DATE DISCHARGED

HOSPITAL ADDRESS	CITY	STATE	ZIP

GIVE NAME AND ADDRESS OF PHYSICIAN(S) CONSULTED

NAME OF PHYSICIAN	ADDRESS	CITY	STATE	ZIP

Any person who, knowingly and with intent to defraud or deceive, fills out this form falsely or omits important facts, may be guilty of a criminal act and subject to criminal penalties.

I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person, that has any records or knowledge of me or my health to give to The MEGA Life and Health Insurance Company, or its reinsurers, any such information. A photocopy of this authorization is to be considered as valid as the original.

VALID ONLY WITH SIGNATURE

*Patient's Signature _____ Date _____

*Patient, Parent (if a minor), Next of Kin or Legal Representative (if patient deceased)

ME000101

STANDARD HEALTH INSURANCE CLAIM FORM
TO BE COMPLETED BY YOUR PHYSICIAN

PATIENT & INSURED INFORMATION

1. PATIENT'S NAME (First name, middle initial, last name)
2. PATIENT'S DATE OF BIRTH
3. INSURED'S NAME(First name, middle initial, last name)
4. PATIENT'S ADDRESS (Street, city, state, ZIP code)
5. PATIENT'S SEX — MALE ☐ FEMALE ☐
6. INSURED'S ID MEDICARE AND/OR MEDICAID NO. (include any letters)
7. PATIENT'S RELATIONSHIP TO INSURED — SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐
8. INSURED'S GROUP NO. (Or Group Name)
9. OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number
10. WAS CONDITION RELATED TO
   A. PATIENT'S EMPLOYMENT — YES ☐ NO ☐
   B. AN AUTO ACCIDENT — YES ☐ NO ☐
11. INSURED'S ADDRESS (Street, city, state, ZIP code)
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
   I Authorize the Release of any Medical Information Necessary to Process this Claim and Request Payment of MEDICARE/CHAMPUS Benefits Either to Myself or to the Party Who Accepts Assignment Below
   SIGNED DATE
13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW
   SIGNED (Insured or Authorized Person)

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
15. DATE FIRST CONSULTED YOU FOR THIS CONDITION
16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES ☐ NO ☐
17. DATE PATIENT ABLE TO RETURN TO WORK
18. DATES OF TOTAL DISABILITY — FROM — THROUGH
   DATES OF PARTIAL DISABILITY — FROM — THROUGH
19. NAME OF REFERRING PHYSICIAN
20. FOR SERVICES RELATED TO HOSPITAL GIVE HOSPITALIZATION DATES — ADMITTED — DISCHARGED
21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (if other than home or office)
22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ NO ☐ CHARGES
23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1. 2. 3. ETC OR DX CODE
   1.
   2.
   3.
   4.

24. A DATE OF SERVICE	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN — PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F

25. SIGNATURE OF PHYSICIAN OR SUPPLIER — SIGNED DATE
26. ACCEPT ASSIGNMENT YES ☐ NO ☐
27. TOTAL CHARGE
28. AMOUNT PAID
29. BALANCE DUE
30. YOUR SOCIAL SECURITY NO.
31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.
32. YOUR PATIENT'S ACCOUNT NO.
33. YOUR EMPLOYER ID NO.
ID NO.

ME000102

*PLACE OF SERVICE CODES

1-(IH)-INPATIENT HOSPITAL
2-(OH)-OUTPATIENT HOSPITAL
3-(O)-DOCTOR'S OFFICE
4-(H)-PATIENT'S HOME
5- DAY CARE FACILITY (PSY)
6- NIGHT CARE FACIKITY (PSY)
7-(NH)-NURSING HOME
8-(SNF)-SKILLED NURSING FACILITY
9- AMBULANCE
0-(OL)-OTHER LOCATIONS
A-(IL)-INDEPENDENT LABORATORY
B- OTHER MEDICAL/SURGICAL FACILITY

The MEGA Life and Health Insurance Company
Insurance Center
P.O. Box 982009 North Richland Hills, TX 76182-8009

We want to pay your claim promptly. You can help by printing clearly with a black pen.

CLAIMANT'S STATEMENT

PRIMARY INSURED	HEALTH ID NUMBER	TELEPHONE NUMBER
WILLIAM V MEADOWS	053301047	( )

ADDRESS | CITY | STATE | ZIP

PATIENT'S NAME (IF A DEPENDENT) | DEPENDENT'S DATE OF BIRTH

DOES THE PATIENT HAVE ANY OTHER HEALTH INSURANCE? YES ☐ NO ☐ (IF YES, COMPLETE THE FOLLOWING)

NAME OF EMPLOYER/POLICY HOLDER | POLICY NUMBER | EFFECTIVE DATE

NAME OF OTHER INSURANCE COMPANY | GROUP [ ] OR INDIVIDUAL [ ]

OTHER INSURANCE COMPANY LOCAL CLAIM OFFICE ADDRESS | CITY | STATE | ZIP

ARE YOU RECEIVING OR APPLYING FOR WORKMEN'S COMPENSATION? YES ☐ NO ☐

COMPLETE THIS SECTION IF CLAIM IS DUE TO AN ILLNESS

DATE ILLNESS BEGAN | DATE OF FIRST TREATMENT | TREATED BY WHOM/WHERE

DESCRIBE ILLNESS

COMPLETE THIS SECTION IF CLAIM IS DUE TO AN ACCIDENT

DATE OF ACCIDENT | DATE OF FIRST TREATMENT | DESCRIBE HOW, WHEN, AND WHERE ACCIDENT OCCURRED

COMPLETE THIS SECTION IF YOU WERE CONFINED TO A HOSPITAL

NAME OF HOSPITAL | DATE ADMITTED | DATE DISCHARGED

HOSPITAL ADDRESS | CITY | STATE | ZIP

GIVE NAME AND ADDRESS OF PHYSICIAN(S) CONSULTED

NAME OF PHYSICIAN | ADDRESS | CITY | STATE | ZIP

Any person who, knowingly and with intent to defraud or deceive, fills out this form falsely or omits important facts, may be guilty of a criminal act and subject to criminal penalties.

I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person, that has any records or knowledge of me or my health to give to The MEGA Life and Health Insurance Company, or its reinsurers, any such information. A photocopy of this authorization is to be considered as valid as the original.

VALID ONLY WITH SIGNATURE

*Patient's Signature _____ Date _____

*Patient, Parent (if a minor), Next of Kin or Legal Representative (if patient deceased)

ME000103

STANDARD HEALTH INSURANCE CLAIM F
TO BE COMPLETED BY YOUR PHYSICIAN

PATIENT & INSURED INFORMATION

1. PATIENT'S NAME (First name, middle initial, last name)

2. PATIENT'S DATE OF BIRTH

3. INSURED'S NAME(First name, middle initial, last name)

4. PATIENT'S ADDRESS (Street, city, state, ZIP code)

5. PATIENT'S SEX
MALE ☐ ☐ FEMALE

6. INSURED'S ID MEDICARE AND/OR MEDICAID NO. (include any letters)

7. PATIENT'S RELATIONSHIP TO INSURED
SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

8. INSURED'S GROUP NO. (Or Group Name)

9. OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number

10. WAS CONDITION RELATED TO
A. PATIENT'S EMPLOYMENT
YES ☐ NO ☐
B. AN AUTO ACCIDENT
YES ☐ NO ☐

11. INSURED'S ADDRESS (Street, city, state, ZIP code)

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
I Authorize the Release of any Medical Information Necessary to Process this Claim and Request Payment of MEDICARE/CHAMPUS Benefits Either to Myself or to the Party Who Accepts Assignment Below
SIGNED DATE

13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW
SIGNED (Insured or Authorized Person)

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

15. DATE FIRST CONSULTED YOU FOR THIS CONDITION

16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS?
YES ☐ ☐ NO

17. DATE PATIENT ABLE TO RETURN TO WORK

18. DATES OF TOTAL DISABILITY
FROM THROUGH

DATES OF PARTIAL DISABILITY
FROM THROUGH

19. NAME OF REFERRING PHYSICIAN

20. FOR SERVICES RELATED TO HOSPITAL GIVE HOSPITALIZATION DATES
ADMITTED DISCHARGED

21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (if other than home or office)

22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE?
YES ☐ NO ☐ CHARGES

23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1. 2. 3. ETC OR DX CODE
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25. SIGNATURE OF PHYSICIAN OR SUPPLIER
SIGNED DATE

26. ACCEPT ASSIGNMENT
YES ☐ NO ☐

27. TOTAL CHARGE

28. AMOUNT PAID 29. BALANCE DUE

30. YOUR SOCIAL SECURITY NO.

31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.

32. YOUR PATIENT'S ACCOUNT NO.

33. YOUR EMPLOYER ID NO.

ID NO.

ME000104

*PLACE OF SERVICE CODES

1-(IH) -INPATIENT HOSPITAL
2-(OH) -OUTPATIENT HOSPITAL
3-(O) -DOCTOR'S OFFICE
4-(H) -PATIENT'S HOME
5- DAY CARE FACILITY (PSY)
6- NIGHT CARE FACIKITY (PSY)
7-(NH) -NURSING HOME
8-(SNF) -SKILLED NURSING FACILITY
9- AMBULANCE
0-(OL) -OTHER LOCATIONS
A-(IL) -INDEPENDENT LABORATORY
B- OTHER MEDICAL/SURGICAL FACILITY

ENDORSEMENT

Attached to and made a part of Policy/Certificate No. 053301047

In consideration of issuance, the Policy/Certificate is hereby amended and modified as follows:

THERE IS NO COVERAGE OR BENEFITS PROVIDED FOR LOSSES DUE TO ANY DISEASE AND/OR DISORDER OF THE HEART AND/OR CIRCULATORY SYSTEM ON WILLIAM V MEADOWS.

THERE IS NO COVERAGE OR BENEFITS PROVIDED FOR LOSSES DUE TO ANY DISORDER AND/OR DISEASES OF THE URINARY SYSTEM ON JEANIE L MEADOWS.

anything in said Policy/Certificate to the contrary notwithstanding. This Endorsement is effective on the Effective Date of the Policy/Certificate and shall expire concurrently with said Policy/Certificate unless otherwise terminated.

In Witness Whereof, MEGA LIFE AND HEALTH INSURANCE COMPANY has issued this Amendment to the Policy/Certificate.

APPLICANT SIGNATURE (if required) DATE

SECRETARY PRESIDENT

ME000105

HEND96

XXXXX05002

THE MEGA LIFE AND HEALTH INSURANCE COMPANY

A Stock Company
(Hereinafter called: the Company, We, Our or Us)
Home Office: Oklahoma City, Oklahoma
Administrative Office: P.O. Box 982010
North Richland Hills, Texas 76182-8010
Customer Service: 1-800-527-5504

WILLIAM V MEADOWS
1113 OAK AVENUE
ELBA AL 36323

Re: Certificate Number: 09053301047

Dear MR. WILLIAM V MEADOWS

The enclosed Alabama Amendatory Endorsement has been created to comply with current state laws pertaining to Claim Payments regarding the time allowed to process a claim. This Form is intended to attach to your current Certificate, and is effective as of your original Certificate date. The application that is attached to your original Certificate still forms a part of your coverage with us, so please retain a copy for your records.

We appreciate this opportunity to service your insurance needs. If you have any questions regarding this enclosure, please contact our Customer Care Service Center at 1-800-527-5504 Monday through Friday, 8:00 a.m. to 5:00 p.m.

Sincerely,

Customer Care Center

The MEGA Life and Health Insurance Company

0P09053301047AL

ME000106

THE MEGA LIFE AND HEALTH INSURANCE COMPANY

A Stock Company
(Hereinafter called: the Company, We, Our or Us)
Home Office: Oklahoma City, Oklahoma
Administrative Office: P.O. Box 982010
North Richland Hills, Texas 76182-8010
Customer Service: 1-800-527-5504

AMENDATORY ENDORSEMENT

This Amendatory Endorsement is made a part of the Group Policy and Certificate to which it is attached. It is subject to all the provisions of the Group Policy which are not inconsistent with this endorsement. It is applicable only to Insured Persons who are residents of the State of Alabama.

1. The following definitions under the **DEFINITIONS** section are hereby deleted and replaced with the following:

   - **Eligible Dependent** means Your lawful spouse and Your unmarried natural and adopted children and step-children who are under 19 years of age (the Limiting Age). The Limiting Age is extended from the child's 19th birthday to the child's 24th birthday if the child is enrolled as a full-time student and attends classes regularly at an accredited college or university.

   - **Pre-Existing Condition** means a medical condition, Sickness or Injury not excluded by name or specific description for which:
     1. Medical advice, Consultation, or treatment was recommended by or received from a Physician within a one year period prior to the Effective Date of Coverage; or
     2. Symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the one year period before the Effective Date of Coverage.

2. The following definition is added under the **DEFINITIONS** section:

   - **Clean Claim** means a claim for purpose of payment of covered health care expenses that is submitted to Us on the claim form which contains substantially all of the required data elements necessary for accurate adjudication, without obtaining additional information from the provider of the service or from a third party. In no event shall We require that the health care provider submit information or data elements in excess of those required on the standard health insurance claim format as a condition to the acceptance and processing of an initial claim as a Clean Claim.

3. The following Covered Expenses are added to the BENEFITS section. Unless otherwise stated, all Covered Expenses are subject to the Deductible, Coinsurance and Lifetime Maximum Amount shown in the CERTIFICATE SCHEDULE; the Maximum Benefit, Benefit and/or Aggregate Maximum Amounts, if any, shown in the CERTIFICATE SCHEDULE; and the Coinsurance Maximum and Copayments, if any, shown in the CERTIFICATE SCHEDULE. Unless otherwise stated, these Covered Expenses are also subject to the EXCLUSIONS AND LIMITATIONS and all other provisions of the Group Policy:

   - **Mammography Screening**

     Covered Expenses include charges for Mammography Screening for the presence of breast cancer for an insured adult female at the following age intervals:
     1. A single mammography screening once every two years for women ages forty (40) to forty-nine (49), unless Your Physician determines, due to certain risk factors, that a mammography screening is required more often; and
     2. A single mammography screening once per Calendar Year for women age fifty (50) and older, unless Your Physician determines, due to certain risk factors, that a mammography screening is required more often.

ME000107

- **Minimum Stay Requirements For Covered Maternity Care**

  This provision applies to an Insured Person's coverage only when the Insured Person incurs Covered Expenses for a normal childbirth or cesarean section delivery that is covered by an optional Maternity Benefit Rider or for Complications of Pregnancy as defined in the Certificate. A minimum of 48 hours of inpatient care will be provided to the mother and newborn child following a vaginal delivery and 96 hours following a cesarean section. Any normal childbirth delivery is subject to the Maximum Benefit for Pregnancy/Childbirth as stated in the optional Maternity Benefit Rider.

- **Colorectal Cancer Screening**

  Covered Expenses include charges for colorectal cancer examinations for Insured Persons who are 50 years of age or older, or for Insured Persons who are less than 50 years of age and at high risk for colorectal cancer according to current American Cancer Society colorectal cancer screening guidelines.

  Current American Cancer Society Guidelines for Colorectal Cancer Screening

  Beginning at age 50, both men and women should follow one of these five testing schedules:

  - yearly fecal occult blood test (FOBT)*;
  - flexible sigmoidoscopy every 5 years;
  - yearly fecal occult blood test* plus flexible sigmoidoscopy every 5 years**;
  - double-contrast barium enema every 5 years; or
  - colonoscopy every 10 years.

  *For FOBT, the take-home multiple sample method should be used.
  **The combination of FOBT and flexible sigmoidoscopy is preferred over either of these two tests alone.

  All positive tests should be followed up with a colonoscopy.

  People should begin colorectal cancer screening earlier and/or undergo screening more often if they have any of the following colorectal cancer risk factors.

  - a personal history of colorectal cancer or adenomatous polyps;
  - a strong family history of colorectal cancer or polyps (cancer or polyps in a first-degree relative younger than 60 or in two first-degree relatives of any age). Note: a first degree relative is defined as a parent, sibling, or child;
  - a personal history of chronic inflammatory bowel disease; or
  - a family history of an hereditary colorectal cancer syndrome (familial adenomatous polyposis or hereditary non-polyposis colon cancer).

4. The **Claim Payments** provision under the **GENERAL PROVISIONS** section is hereby deleted and replaced as follows:

- **Claim Payments**

  We will pay all benefits due under the Group Policy within 30 days upon receipt of a Clean Claim that is filed electronically or 45 days upon receipt of a Clean Claim that is filed on paper. If We are denying or pending the claim, We shall notify the health care provider or certificate holder of the reason for denying or pending the claim and what, if any, additional information is required to process the claim.

  Any undisputed portion of the claim shall be paid in accordance with the foregoing schedule. If We fail to deny or pay a Clean Claim within the time periods, then the amount of the overdue claim shall include an interest payment of 1.5% per month, prorated daily, which shall accrue from the date the payment was overdue and shall be payable at the time that the claim is paid.

5. The first paragraph in the **Subrogation** provision under the **GENERAL PROVISIONS** section is hereby deleted and replaced as follows:

- **Subrogation**

  You agree that We shall be subrogated to any Insured Person's right to damages, provided such Insured Person has been made whole, to the extent of the benefits provided by the Certificate, for Injury or Sickness that a third party is liable for or causes. In the event that We retain Our own attorney to represent Our subrogation interest, We will not be responsible for paying a portion of Your attorney fees or costs.

In Witness whereof, the Insurance Company has caused this Amendment to be signed by its President and Secretary.

Signed for The MEGA Life and Health Insurance Company at North Richland Hills, Texas.

Secretary

President

ME000109